

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Cass  
Township Adair  
or  
Village  
or  
City

Registration District No. 1650 File No. June 17  
Primary Registration District No. 51890 Registered No. 3

FULL NAME

Polly James

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE ☒ MARRIED ☒ WIDOWED ☒ OR DIVORCED ☐ (Write the word) Widowed

DATE OF BIRTH

SEP 1887  
(Month) (Day) (Year)

AGE

90 yrs. 11 mos. 11 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

00-0

BIRTHPLACE

(City or town, State or foreign country)

Kentucky

NAME OF FATHER

unknown

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

unknown

MAIDEN NAME OF MOTHER

unknown

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

June 17 1913 W. A. Rice  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

June 17 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

X X, 1913, to X X, 1913,

that I last saw he alive on June 16, 1913,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:

old age

1671

154

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory  
(SECONDARY)

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed)

X X X X M. D.

1913 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

Home

At place of death June 17 mos. 11 ds. In the Mo yrs. 11 mos. 0 ds.

Where was disease contracted  
If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Benton Co Mo

DATE OF BURIAL

June 18 1913

UNDERTAKER

W. A. Walls

ADDRESS

Sagrada

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases, resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Camden  
Township Adair  
Village \_\_\_\_\_  
City \_\_\_\_\_

Registration District No. 1150 File No. \_\_\_\_\_  
Primary Registration District No. 5169a Registered No. 3  
St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Polly Tomas

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Satisfactory Information Supplied  
DATE OF BIRTH unknown  
AGE 96 yrs. 11 mos. Supplied  
OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
BIRTHPLACE (City or town, State or foreign country) Kentucky

DATE OF DEATH June 17, 1913  
I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 191\_\_\_\_, to \_\_\_\_\_ 191\_\_\_\_,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows: \_\_\_\_\_

PARENTS

NAME OF FATHER unknown  
BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
MAIDEN NAME OF MOTHER unknown  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

Contributory (Secondary) \_\_\_\_\_  
(Signed) Gibe \_\_\_\_\_  
191\_\_\_\_ (Address) Pollock

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Polly Tomas  
(ADDRESS) Adair  
Filed June 17, 1913  
REGISTRAR W. A. Rice

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_  
PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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[Approved by U. S. Census and American Public Health Association]

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19106  
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